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IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

RANDON BRAGDON, D.M.D.,
Petitioner,
v.
SIDNEY ABBOTT, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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QUESTIONS PRESENTED

Amicus curiae will address the following questions:

Does an individual with early, or "asymptomatic," HIV disease have a "disability" within the meaning of the Americans with Disabilities Act?

Under the Americans with Disabilities Act, should a court defer to a health care practitioner's subjective judgment about the presence of a "direct threat" of infection posed by an individual who seeks treatment in the office of that practitioner, when the overwhelming weight of scientific evidence demonstrates that any such risk is insignificant?

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BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

INTEREST OF *AMICUS CURIAE*

This case calls upon the Court to revisit the framework, established in *School Bd.* v. *Arline*, 480 U.S. 273 (1987), for evaluating claims of discrimination by persons who suffer from an infectious disease.[1] Specifically, this case presents two important questions: First, does a person with early HIV disease, sometimes called "asymptomatic HIV disease," have a "disability" as that term is defined

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[1] Pursuant to Rule 37.6 of the Rules of this Court, *amicus* states that no counsel for a party authored this brief in whole or in part, and that no person or entity other than *amicus* and its counsel made any monetary contribution to the preparation or submission of this brief. Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief, and the consent letters have been filed with the Clerk of the Court.

in the Americans with Disabilities Act ("the Act" or "the ADA")? Second, to what extent should courts defer to a health care practitioner's subjective judgment about the presence of a "direct threat" of infection in a particular practice setting? As the nation's largest organization of physicians, *amicus* American Medical Association ("AMA") has a vital interest in both questions.

The AMA's nearly 300,000 member physicians are regularly called upon to care for persons with infectious diseases, including early HIV disease. The AMA and its members thus have a substantial interest in ensuring that these patients receive treatment that reflects informed and medically reasonable judgments about the risks of infection. To that end, for more than a decade, the AMA has sponsored extensive efforts to ascertain the facts about HIV disease and its transmission and to disseminate those facts to physicians and the public.

Most notably, in an ethical opinion adopted in 1992, the AMA confirmed, specifically in the context of HIV disease, a physician's age-old ethical obligation to treat patients with a communicable disease. AMA, *Code of Medical Ethics* § 9.131 (1996-97 ed.), AMA *Amicus* App. 1a. This opinion, embraced after extensive debate and analysis, holds that "[a] physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV," and that "[p]ersons who are seropositive should not be subjected to discrimination based on fear or prejudice." *Id.* This duty to treat is further reinforced by an additional ethical opinion that "physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, or any other basis that would constitute invidious discrimination" (*id.* § 9.12, AMA *Amicus* App. 1a)—an opinion that the AMA, in educational materials addressing the physician's legal obligations under the ADA, has made clear forbids refusal to treat patients with HIV. These ethical opinions have been widely disseminated by the AMA, have been cited in numerous judicial opinions and journal articles, and are the subject of extensive and continuing AMA efforts and initiatives aimed at public awareness and continuing physician education.

The AMA believes that the medical considerations underlying its position regarding the ethical obligation of physicians to treat individuals who are HIV+ are highly relevant to the proper resolution of this case. The plain medical fact is that HIV disease, even in its early stages, has profound effects on a person's health. HIV-infected individuals require access to routine medical services. Moreover, the general consensus of medical opinion, both in 1994 and today, is that there is no significant risk of transmission of HIV from patient to practitioner arising out of the delivery of routine care in the medical or dental office by a practitioner who takes certain straightforward "universal precautions." In these circumstances, it is not medically appropriate to refuse to provide such care in an office setting to individuals with early HIV disease.

MEDICAL BACKGROUND

We begin with a discussion of infectious diseases generally and, in particular, important aspects of HIV disease. This discussion includes both the progression of HIV disease from infection through its severe stages and the risks of HIV transmission from patients to health care workers and specifically to dentists. In analyzing the nature, duration, severity, and risks of HIV transmission, we focus on data from the 1994 time frame, *i.e.*, the time when respondent Abbott was denied treatment, because, as the court of appeals correctly concluded, "neither the service provider nor the prospective recipient of the service may prove or disprove the direct threat defense by relying on medical evidence not available when treatment was refused." Pet. App. 18a.

A. Infectious Diseases in the United States

Each year, millions of Americans contract infectious, or communicable, diseases.[2] See Centers for Disease Control & Prevention ("CDC"), 46 Morbidity and Mortality Weekly Report ("MMWR") 1259 (Jan. 1998) (table 1) (year-end figures for select diseases). More than 200 different infectious diseases have been identified, including hepatitis, lyme disease, meningitis, pneumonia, tetanus, tuberculosis, and HIV disease. See *Control of Communicable Diseases in Man* ix-xv (A. Benenson ed., 15th ed. 1990). The consequences of contracting an infectious disease vary widely, ranging from minor irritation to paralysis or death. In some cases, a person with an infectious disease may have no outwardly apparent symptoms at all.

B. Human Immunodeficiency Virus and HIV Disease

The condition known as acquired immunodeficiency syndrome ("AIDS") was first reported to the CDC in 1981. See CDC, *Pneumocystis Pneumonia—Los Angeles*, 30 MMWR 250 (1981). In 1983, HIV, the pathogen responsible for AIDS, was identified. As more information about the nature and continuous progression of the HIV disease process accumulated, the term AIDS "became outdated from a clinical perspective." Michael S. Saag, *Clinical Spectrum of Human Immunodeficiency Virus Diseases*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 203, 203 (Vincent T. DeVita, Jr. *et al.* eds., 4th ed. 1997) (hereinafter "Saag"). In current usage, "AIDS" is primarily an epidemiological category

[2] The words "infectious" and "communicable" are often used interchangeably. An "infectious disease" or "communicable disease" refers to a disease that is capable of being transmitted to others at some time. When someone is currently capable of transmitting a disease to others, he or she is referred to as being "infectious" or "contagious," or (less frequently) "communicable." *Dorland's Illustrated Medical Dictionary* 359, 372, 838 (28th ed. 1994).

that is used to track the number of new cases of persons with advanced HIV disease, rather than a clinical term that is relevant to patient care. *Id.*

HIV is a human virus that can infect and replicate in numerous types of human cells. Paul A. Volberding, *Clinical Spectrum of HIV Disease*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 123, 124 (Vincent T. DeVita, Jr. *et al.* eds., 3d ed. 1992) (hereinafter "Volberding"). Certain immune-system T-cells—those with a molecule known as CD4—are particularly susceptible to HIV infection. *Id.* Infected T-cells (T-cells that are "CD4+") eventually die, and as the number of such cells decreases, the body's ability to fight infection also decreases. The infected individual's CD4+ cell count is thus "the best predictor of the [individual's] relative risk for developing HIV-related opportunistic diseases" at any given time. Saag at 203. As a result, HIV disease is viewed as progressing in stages that correspond to a range of CD4+ cell levels in the patient. *Id.* at 203-04; Volberding at 126.

1. *Progression and Effects of HIV Disease*

HIV disease begins with infection by HIV. There are three basic routes of HIV transmission: (1) invasive exposure to blood, blood products, or other infectious bodily fluids, as in individuals who share contaminated needles for intravenous drugs or who receive contaminated blood; (2) prenatal or perinatal exposure (*i.e.*, from mother to infant)[3]; and (3) intimate sexual contact with a partner who is HIV+. Volberding at 127; Anthony S. Fauci & H. Clifford Lane, *The Acquired Immunodeficiency Syndrome (AIDS)*, in *Harrison's Principles of Internal Medicine* 1392, 1393 (Eugene Braunwald *et al.* eds., 11th ed. 1987).

[3] HIV may also be transmitted postnatally from mother to infant through breast milk. Committee on Pediatric AIDS, *Human Milk, Breastfeeding, and Transmission of Human Immunodeficiency Virus In the United States*, 96 Pediatrics 977, 977 (1995).

"HIV infection induces a disease process that is continuous and progressive." Volberding at 125. There is, in fact,

> a single, continuous disease process beginning with the initial exposure to the infectious agent and terminating in the advanced forms of immune deficiency, with death resulting from the complex interactions between the HIV infection itself and the secondary opportunistic infections and malignancies.

Id. at 126. With advances in treatment, increasing numbers of patients with HIV are surviving longer, but the disease is generally fatal. See Saag at 208 ("it appears inevitable that all patients with HIV-1 infection will ultimately succumb to their disease"). Apart from a number of HIV-related gynecological manifestations, "there is little gender difference in opportunistic processes and HIV disease progression." Rebecca Clark, *Clinical Manifestations and the Natural History of Human Immunodeficiency Virus Infection in Women*, in *Medical Management of AIDS in Women* 115, 115 (Deborah Cotton & D. Heather Watts eds., 1997); see also Howard L. Minkoff & Jack A. DeHovitz, *Care of Women Infected With the Human Immunodeficiency Virus*, 266 JAMA 2253, 2255-56 (Oct. 23/30, 1991) ("There is no specific evidence that nongynecologic opportunistic manifestations of HIV disease differ between men and women.").

The median time from estimated initial HIV infection to the development of symptoms of advanced HIV disease is roughly 10 to 12 years. Saag at 209; Volberding at 129. Importantly, the rate at which HIV disease progresses varies widely from person to person. The reasons for this variability are not well understood. According to Saag, "the rate of disease progression is quite variable, with some individuals progressing to AIDS within months of the initial infection and others remaining free of AIDS-defining conditions for more than 15 to 20 years (i.e., long-term nonprogressors)." Saag at 209; see also Volberding at 129 (same). Accordingly, "[f]or any HIV-1-

infected individual," however, "the likelihood of the disease progression is difficult to predict." Saag at 203.

The first stage of HIV disease is known as "acute retroviral syndrome" or "acute seroconversion syndrome." Volberding at 127-28; Saag at 204-05. This complex of symptoms generally begins two to six weeks after initial infection. Saag at 204. The symptoms, which include fevers, lymphadenopathy (*i.e.*, chronic abnormal enlargement of the lymph nodes), pharyngitis, and diffuse skin rash, most closely resemble acute mononucleosis or a severe case of the flu. Volberding at 127. Most symptoms resolve within 14 to 21 days, Saag at 205, but lymphadenopathy often persists throughout early HIV disease, Volberding at 127. These symptoms are indicative of HIV's direct and immediate attack on the cells of the immune system. After the HIV cell attaches to the CD4 receptor on a lymph cell, its membrane fuses with that of the lymph cell and its viral genetic material is injected into the host. Volberding at 124. The host can then become a factory for the production of more copies of HIV's genetic material, and these copies spread to other cells. *Id.* Indeed, within two to four weeks after initial infection, high levels of circulating HIV are detectable. Within one to three weeks after the onset of acute retroviral syndrome, HIV antibodies are detectable. Saag at 205.

The second stage of HIV disease is known as early, or asymptomatic, HIV disease. It is characterized by a CD4+ count of 500 to 750 cells/mm^3. *Id.* at 205; Volberding at 126 (Table 9-1). This is the longest stage of HIV disease, with a typical duration of 10+ years. Volberding at 126 (Table 9-1, line 3). Lymphadenopathy is the only typical symptom that is readily apparent to the patient, and it usually persists from the time of acute seroconversion. Saag at 205-06; Volberding at 128. A consistent pattern of irregularities in the blood and immune symptoms can also be detected with laboratory tests. Volberding at 128. Finally, a range of dermatological abnormalities and oral lesions are not uncommon during

this phase. Saag at 206. This stage of the disease requires consistent monitoring and routine medical care to prevent, so far as is practicable, the onset of opportunistic infections. Volberding at 130-31.

As was noted above, CD4+ cell count is the most important marker of the disease's progression, and it declines steadily throughout early HIV disease. As HIV continues its attack on the immune system, a person with HIV experiences "an insidious, progressive decline in CD4+ cells (40 to 80 cells/mm^3 per year)." *Id.* at 207. Without antiretroviral therapy, there is "an enormously high degree of viral production throughout all stages of infection," depriving the immune system of any respite from HIV's assault. *Id.* at 206.

As the CD4+ count drops below 500 cells/mm^3, the individual is likely to pass from the asymptomatic to the symptomatic stage of HIV disease. *Id.* at 207; Volberding at 126 (Table 9-1). Symptomatic HIV disease can range in duration, from a brief period ending in death to a number of years. Volberding at 126 (Table 9-1). Symptoms at this stage include night sweats, chronic diarrhea, fever, weight loss, fatigue, and more frequent or severe skin and oral lesions. Saag at 207; Volberding at 131-32. Indeed, "[n]early every organ system in the body can be affected," and "the effect of symptoms on the patient ranges from minimal to devastating." Volberding at 131. When an individual with HIV reaches the final stages of the disease, CD4+ counts fall below 200 cells/mm^3 and continue to decline. Opportunistic infections such as *pneumocystis carinii* pneumonia, encephalitis, and B-cell lymphoma begin to appear. Saag at 207; Volberding at 133. When CD4+ counts drop below 50 cells/mm^3, an increasing array of opportunistic infections must be treated. Saag at 208. Brain disorders and involuntary weight loss, or "wasting," are also common at this stage. *Id.*

With aggressive antiretroviral therapy and prophylactic treatments designed to fend off opportunistic infections,

this stage of the disease can be managed for some time despite the profound immunosuppression brought about by HIV. Saag at 207-09; Volberding at 133-34. Nevertheless, deaths at this late stage of HIV disease remain common. Saag at 208. As one authority has put it,

> the diagnosis of terminal-stage HIV-1 disease is usually based on an inability to control the symptoms of disease, because no treatments are available for the particular disorder or, more commonly, because available treatments become ineffective.

Id. at 208-09.

The effects of HIV disease are not limited to the clinical effects already discussed. Individuals who have learned that they are HIV+ must adapt to a daunting new personal circumstance:

> HIV leads to a deterioration of the patient's health, requires ongoing medical and subspeciality care, results in frequent hospitalizations, can be painful, often requires embarrassing and invasive procedures, and usually leads to premature death. It also disrupts the patient's ability to engage in usual activities such as school or work and has a devastating psychologic and emotional effect on the individual and his or her family.

Sandra Y. Lewis *et al., Pediatric and Family HIV: Psychosocial Concerns Across the Continuum of Disease*, 31 Nursing Clinics N. Am. 221, 221 (Mar. 1996). It is not difficult to recognize that, in light of this harsh reality, "HIV is the most feared disease in our society." Jimmie C. Holland *et al., Psychiatric and Psychosocial Aspects of HIV Infection*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 347, 347 (Vincent T. DeVita, Jr. *et al.* eds., 3d ed. 1992) (hereinafter "Holland *et al.*"). And the realization that HIV has transformed—and almost certainly severely shortened—one's life, "can be accompanied by profound feelings of shock, disbelief, depression, loneliness, hopelessness, personal grief, guilt, anger, and fear." Margaret A. Chesney & Susan Folkman, *Psycho-*

logical Impact of HIV Disease and Implications for Intervention, 17 Psychiatric Clinics N. Am. 163, 163 (Mar. 1994).

Indeed, individuals with early HIV disease typically must confront a number of psychosocial issues that affect their quality of life. These include:

> (1) disclosing their serostatus to significant others; (2) seeking meaning in living with an HIV diagnosis; (3) making critical decisions about safer sexual behavior and drug use, reproductive choices, and custody planning for children; (4) adopting healthy coping strategies; (5) seeking social support; (6) managing social distancing in relationships; and (7) coping with the uncertainty of the disease course.

Lynda S. Doll & Beth A. Dillon, *Counseling Persons Seropositive for Human Immunodeficiency Virus Infection and Their Families*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 533, 534 (Vincent T. DeVita, Jr. *et al.* eds., 4th ed. 1997). These challenges not only touch every major area of life activity, but they significantly limit the individual's ability to proceed with daily life without regard to the HIV disease. See *id.* at 534-38 (detailed review of each issue). See also AMA, *HIV Blood Test Counseling: Physician Guidelines* 3-5 (2d ed. 1993).

Finally, the unpredictable rate at which HIV progresses heightens the psychological impact and anguish of being diagnosed with the disease. "[U]ncertainty becomes the central issue of daily life as each body sensation is analyzed for evidence of progression or new infection." Holland *et al.* at 348. The fact that HIV disease may suddenly and rapidly progress to an advanced and debilitating stage severely complicates planning and making decisions about work and family life.

2. *HIV Transmission in the Health Care Setting*

The principal means of HIV transmission in the health care setting is exposure to the blood, blood products, or

other infectious bodily fluids of a person with HIV. The primary risk of transmission from a patient to a health care practitioner comes from percutaneous exposure, such as a needlestick or a cut with a sharp object.[4] See generally David M. Bell, *Human Immunodeficiency Virus Transmission in Health Care Settings: Risk and Risk Reduction*, 91 Am. J. Med. 3B-294S (1991 Supp. 3B).

a. Transmission.—Since the first reported case of occupationally transmitted HIV infection in the health care setting occurred in 1983, the public health community has collected and analyzed epidemiological data to estimate the risk of HIV infection from patients to health care practitioners, including dentists. See David K. Henderson *et al.*, *Risk for Occupational Transmission of Human Immunodeficiency Virus Type 1 (HIV-1) Associated With Clinical Exposures*, 113 Annals Internal Med. 740, 740 (Nov. 15, 1990). Data have been collected in different ways. All of which indicates that the risk of HIV transmission from a patient to a dentist is not significant, as long as easily followed universal precautions are used.

First, public health authorities have created a "passive surveillance" system for collecting and tracking reports of HIV transmission from patient to health care worker. In 1991, the CDC began tracking the number of health care workers who report occupationally acquired HIV infection. Ruthanne Marcus & David M. Bell, *Occupational Risk of Human Immunodeficiency Virus Infection in Health Care Workers*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 645, 645 (Vincent T. DeVita, Jr. *et al.* eds., 4th ed. 1997) (hereinafter "Marcus & Bell"). As of December 1994, the CDC's surveillance data specific to health care workers showed 42 documented cases and 91 possible cases of HIV infection involving

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[4] In some circumstances (not including routine dental procedures for a patient with HIV disease), infections may be transmitted by cutaneous exposure (such as a splash on the skin), or mucocutaneous exposure (such as exposure to the mucous membranes of the sinus).

patient care.[6] *Id.* at 646. None of the documented cases involved a dental practitioner. *Id.* As of June 1997, the number of documented cases of HIV transmission from patient to health care practitioner had risen to 52, but, as before, none of the health care practitioners was a dentist. CDC, *HIV/AIDS Prevention: Facts About Surveillance of Health Care Workers With HIV/AIDS* (Aug. 1997). Given the number of dental procedures performed across the country each year, the lack of a single documented case of HIV transmission from patient to dentist strongly indicates that the risk of such transmission is not significant.[6]

Researchers also have conducted a number of long-term prospective cohort studies that assess the likelihood that a health care worker will become HIV+ after a documented percutaneous exposure to HIV-infected blood. "These studies," published in 1994 or earlier, "have consistently indicated that the risk of acquiring HIV infection after a percutaneous exposure to HIV-infected blood is approximately 0.3%," *i.e.*, 3 in 1,000. Marcus & Bell at 648. This figure of 3 in 1,000 is not, as some have implied, a measure of the risk that a dentist who treats a patient

[5] A "documented case" involves a health care worker's documented conversion from HIV seronegative to HIV seropositive status in connection with a known percutaneous, mucous membrane, or skin exposure. Marcus & Bell at 646. A "possible case" involves a health care worker who reported an occupational exposure to HIV and who had no identifiable behavioral or transfusion risks, but for whom there is no documented proof that, prior to the occupational exposure, the worker did not have HIV. *Id.*

[6] The CDC also has other data linking HIV disease and employment. As of December 31, 1994, the CDC had received reports of 304,651 adults with AIDS for whom employment information was available. Of these people, 14,591 (or 4.8%) had been employed in health care settings. In the workforce as a whole, by comparison, approximately 5.7% of workers are employed in health services. In other words, according to 1994 data, health care workers were "not overrepresented among reported cases of AIDS." Marcus & Bell at 645.

with HIV will become infected with HIV. Rather, that figure must be multiplied by the likelihood that the dentist will be exposed to HIV-infected blood or other fluid through a percutaneous injury in the first place. For dentists, such injuries occur infrequently—on average, once every four months.[7] Moreover, as Marcus & Bell indicate, this 0.3% risk estimate of practitioner HIV infection after exposure to infected blood includes many different types of injuries from source patients at various stages of HIV disease. *Id.* Factors unique to dentistry might tend to lower this estimate. For example, because the needles used to administer local anesthetic are of a smaller bore than those used for many medical procedures, *e.g.*, to draw blood, sticks from such needles will expose dentists to smaller amounts of infected blood. Stephen E. Gruninger *et al.*, *Human Immunodeficiency Virus Type 1 Infection Among Dentists*, 123 J. Am. Dental Ass'n 57, 62-63 (Mar. 1992). It is therefore "difficult . . . to rationalize how accidental needlesticks could be a significant HIV transmission route in the dental operatory." *Id.* at 62.

b. Universal Precautions.—The CDC promulgated recommendations based on universal precautions in 1987. Elizabeth A. Bolyard & David M. Bell, *Universal Precautions in the Health Care Setting*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* 655, 656 (Vincent DeVita, Jr. *et al.* eds., 4th ed. 1997). The principle of universal precautions assumes that blood, certain bodily fluids, and tissues of *all* patients must be considered infectious and treated accordingly. *Id.* at 656. The CDC

[7] The baseline rate of needlestick injuries among dentists has steadily declined during the era of universal precautions. Data from 1993 indicate that, at that time, dentists suffered a percutaneous injury roughly once every four months. Jennifer L. Cleveland *et al.*, *Occupational Blood Exposures in Dentistry: A Decade in Review*, 18 Infect. Control & Hosp. Epidemiol. 717, 720 (Oct. 1997) ("the rate of percutaneous exposures among U.S. dentists decreased steadily from approximately one injury per month in 1986 to one injury every 4 months in 1993"). Given the decline from 1986 to 1993, however, the baseline rate may well be even lower today.

has promulgated and continually updated guidelines based on universal precautions, both for general health care settings and for specialized areas of practice, including dentistry.[8] *Id.* at 656-57. The core practices of universal precautions ("UP") can be readily summarized:

> UP emphasizes the use of appropriate barrier precautions (e.g., gloves, gowns, and facial protection) routinely to prevent mucocutaneous blood contact. The precautions also emphasize the need for prevention of percutaneous injuries through care in the use of needles and other sharp instruments and during disposal of these devices, including the use of conveniently placed sharps disposal units. Proper handwashing, linen and waste handling, and disinfection and sterilization of instruments and other reusable equipment are recommended.

Id. at 657. These practices focus on limiting the health care worker's exposure to blood-borne pathogens such as HIV.

The application of universal precautions to the field of dentistry is straightforward. For example, according to the CDC, "medical gloves (latex or vinyl) always must be worn by [dental health care workers] when there is a potential for contacting blood, blood-contaminated saliva, or mucous membranes." CDC, *Recommended Infection-Control Practices for Dentistry, 1993* 42 MMWR RR-8, at 3 (May 28, 1993), Pet. App. 185a. Likewise, "[c]hin-length plastic face shields or surgical masks and protective eyewear should be worn when splashing or spattering of blood or other body fluids is likely, as is common in dentistry." *Id.*, Pet. App. 186a; see also Jennifer L. Cleveland & Donald W. Marianos, *Special Considerations for Dentistry*, in *AIDS: Etiology, Diagnosis, Treatment and Prevention* (Vincent T. DeVita, Jr. *et al.* eds., 4th ed. 1997)

[8] *See, e.g.*, CDC, *Recommended Infection-Control Practices for Dentistry, 1993*, 42 MMWR RR-8 (May 28, 1993), Pet. App. 181a-199a.

(discussing infection control practices for dentistry). As the CDC states, "[w]hen implemented, these recommendations should reduce the risk of disease transmission in the dental environment." *Recommended Infection-Control* at 1 (summary), Pet. App. 181a. Significantly, the CDC guidelines do not suggest that the risks of HIV transmission are reduced by performing routine medical or dental procedures in hospital, rather than office, settings.

Petitioner notes that these public health guidelines contain no "definitive statement of the significance of the risk to dentists." (Pet. 21.) This criticism is misplaced. The universal precautions guidelines are not intended to provide an exhaustive report of epidemiological data or a static risk estimate. The data regarding the quantum of risk, already reviewed in detail above, are readily available in peer-reviewed journals accessible to petitioner and all other interested health care workers.

Given petitioner's focus on the possibility of HIV infection from aerosolized pathogens (Pet. 16, 19-20), it is useful to focus on epidemiological evidence on this subject. Marcus & Bell recently summarized the evidence regarding aerosol transmission as follows:

> Although inhalation of particles of aerosolized blood may pose a theoretical risk of blood borne pathogen transmission, *no case of such transmission has been documented*. Transmission of blood borne pathogens by aerosols would require generation of aerosolized particles of blood, the presence of infective blood borne pathogens in these aerosolized particles, and the deposition of a sufficient number of infective blood particles in the respiratory tract or on the mucous membranes of a susceptible host to cause infection. . . . Aerosolized HIV has been detected in laboratory studies, although these studies should not be interpreted to mean that HIV is aerosolized in a clinical setting or that HIV is transmitted by this route. . . . Until further research is conducted, the possibility of occupational transmission of HIV

through aerosolized blood should be considered theoretical.

Marcus & Bell at 651 (emphasis added); see also David M. Bell, *Human Immunodeficiency Virus, supra,* at 3B-298S ("There are no known instances of transmission of a blood-borne pathogen by aerosol in a clinical setting."). Any "theoretical" risk of transmission should not alter the conclusion that, on the basis of all known data, there is no significant risk of HIV transmission from patient to dentist during routine dental care provided in accordance with universal precautions.

The American Dental Association's policy statements reflect the absence of significant risk to dentists in providing routine dental care in an office setting using universal precautions. According to the relevant policy statement, first promulgated in 1988 and renewed in 1991, "there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed." American Dental Ass'n, *Policy on AIDS, HIV Infection and the Practice of Dentistry* (1991), J.A. 225. Further, according to the ADA, "[p]atients with HIV infection may be *safely treated in private dental offices* when appropriate infection control procedures are employed." *Id.* (emphasis added).

3. *Ethical Obligation to Treat Infected Patients*

Finally, the duty to treat patients with communicable diseases, and more broadly, the recognition that the practice of medicine requires physicians to accept the risk of transmission of those diseases, is a cornerstone of medical ethics. See, *e.g.*, Ezekiel Emanuel, *Do Physicians Have An Ethical Obligation To Treat Patients With AIDS?*, 318 N. Eng. J. Med. 1686 (1988). In ethical opinions adopted and disseminated well before the facts of this case arose, the AMA has confirmed that physicians may not ethically refuse to treat a patient solely because that patient is seropositive for HIV. AMA, *Code of Medical Ethics*, § 9.131 (1996-97 ed.), AMA *Amicus* App. 1a-2a; see *id.* § 9.12, AMA *Amicus* App. 1a.

SUMMARY OF ARGUMENT

The ADA reflects a national commitment to ensure that no individual is treated unfairly because of a disability and, in particular, to ensure that no person is denied access to health care services because of a medically unreasonable judgment based upon an actual, historical, or perceived disability. The ADA was enacted against the backdrop of this Court's seminal holding, in *School Bd.* v. *Arline*, 480 U.S. 273 (1987), that persons with contagious diseases may be considered handicapped within the meaning of section 504 of the Rehabilitation Act of 1974. The ADA's broad definition of disability confirms Congress's agreement with this Court that "society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment," and that "contagiousness" is particularly likely to give rise to the "public fear and misapprehension" that often leads to discrimination. 480 U.S. at 284 (footnote omitted). It is therefore critical under the ADA, as it was under the Rehabilitation Act, to ensure that decisions about access to health care for individuals who are disabled within the meaning of the Act are based upon "reasonable medical judgments." *Id.* at 288; see, *e.g.*, 42 U.S.C. 12101(a)(3) (Act needed to remedy discrimination against the disabled in "health services").

I.

The Act defines "disability" in three ways. Two of these are relevant here. First, the Act defines a "disability" as an impairment that substantially limits a major life activity. The term also includes being "regarded as" having such an impairment.

Respondent Abbott is covered by both statutory definitions. First, even where outward symptoms have not manifested, a diagnosis of infection with HIV typically affects every aspect of a person's life and substantially limits mul-

tiple life activities. Second, petitioner Bragdon denied respondent access to the routine dental care that he offered to others solely on the basis of respondent's HIV infection. He thus regarded her HIV infection as a physical impairment that substantially limited her eligibility to obtain health care—a crucial aspect of "caring for one's self" that has long been recognized as a major life activity. Thus, the court of appeals correctly concluded that respondent has a "disability" within the meaning of the ADA.

II.

The Act permits a place of public accommodation to deny services to an individual where "such individual poses a direct threat to the health or safety of others." In *Arline*, this Court concluded that, in the context of the possible transmission of an infectious disease such as tuberculosis or HIV, assessing the presence of a "significant health and safety risk[]", 480 U.S. at 287, entails an inquiry "based on reasonable medical judgments given the state of medical knowledge." *Id.* at 288 (quoting AMA *Arline Amicus* Br. at 19). Accordingly, although courts ordinarily should accord substantial deference to a reasonable medical or dental judgment regarding the presence of a health or safety risk, such deference is appropriate only when it is "reasonable" and consistent with "the state of medical knowledge." *Id.*

Here, there was a firm consensus among both private and public health care professionals about the absence of a significant risk of transmission in the treatment context at issue. In these circumstances, petitioner Bragdon's contrary judgment cannot be regarded as reasonable. See *General Elec. Co.* v. *Joiner*, 118 S. Ct. 512 (1997). Moreover, the deference ordinarily shown to a professional judgment is unwarranted where, as here, the practitioner whose judgment contravenes the consensus view was directly involved in the case, did not obtain an independent, medically reasonable opinion before refusing to treat respondent in his office, and did not adhere to an important ethical tenet of his profession.

ARGUMENT

I. GIVEN THE STATE OF MEDICAL KNOWLEDGE AND PRACTICE IN 1994, RESPONDENT HAD A "DISABILITY" AS DEFINED BY THE ACT

The Act defines a "disability" in two ways that are relevant here. First, a "disability" is "a physical or mental impairment that substantially limits one or more of the major life activities of [the] individual." 42 U.S.C. § 12102(2)(A). Second, a "disability" includes "being regarded as having such an impairment," *i.e.*, a physical or mental impairment that substantially limits one or more of a person's major life activities. 42 U.S.C. § 12102(2)(C). Given the facts about HIV as they were known in 1994, virtually all persons suffering from early HIV disease, including respondent Abbott, should be found to have a disability under the first definition. In addition, petitioner's refusal to treat respondent solely on the basis of her early HIV disease demonstrates that he regarded her as having a substantially limiting impairment, bringing this case within the alternative definition of "disability."

A. Persons With Early HIV Disease Have An Impairment That Likely Substantially Limits Many Major Life Activities

The court of appeals' conclusion that HIV, "whether symptomatic or asymptomatic, comprises a physical impairment under the ADA" (Pet. App. 6a) is fully consistent with the current state of medical knowledge about HIV disease. See pages 5-9, *supra*. Petitioner has not challenged that conclusion in this Court. Indeed, to suggest otherwise would conflict with established medical facts about the nature and progression of HIV disease.[9]

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[9] *See also* 28 C.F.R. § 36.104 (1997) (DOJ regulations implementing the Act's public accommodations provisions, defining "physical

Petitioner challenges, instead, the lower courts' conclusion that reproduction—"intimate sexual activity, gestation, giving birth, childrearing, and nurturing familial relations," (Pet. App. 7a)—is a "major life activity" for purposes of the definition of "disability."[10] To focus exclusively on reproduction as *the* major life activity substantially limited by HIV, however, is to ignore much of the profound impact of HIV disease. Even asymptomatic HIV disease has a debilitating effect on many other major life activities. These include life-shaping decisions such as what education to pursue, what family and financial obligations to assume, what employment opportunities to seek or to forgo and, at bottom, how to spend the limited time left to live. It is simply inconsistent with human experience to say that HIV disease, which profoundly affects a person's ability to plan for and engage in a host of basic life activities, does not substantially limit them.[11]

Recognizing that HIV infection can have a substantial effect on major life activities of virtually all those who are

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impairment" as, *inter alia*, "HIV disease (whether symptomatic or asymptomatic)"); 45 C.F.R. § 84.3(j)(2) (1997) (HHS regulations implementing the Rehabilitation Act, defining "physical impairment" as, *inter alia*, a physiological disorder of the hemic and lymphatic systems). HIV disease attacks and impairs the body's immune system relentlessly from the moment of infection.

[10] *Amicus* concurs with the court of appeals' conclusion that reproduction encompasses a cluster of life activities of profound scope and widely recognized importance, and is comparable to the life activities identified by regulation as "major." *See* 28 C.F.R. § 36.104 (1997) ("The phrase *major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."); 45 C.F.R. § 84.3(j)(2)(ii) (1997) (same).

[11] The impact of HIV infection on these basic life decisions is made all the more profound and intractable by the unpredictable nature of the clinical course of an individual person's HIV disease. The variability in life expectancy for someone infected with HIV is such that no individual can know whether he or she will live for 10 or 15 years or more—or die within months or a few years. *See* page 6-7, *supra*.

infected is fully consistent with the nature and purpose of the Act. The Act is intended to prevent discrimination against disabled individuals in arenas as diverse as employment, 42 U.S.C. § 12112(a), entitlement to government services, *id.* § 12132, and access to public accommodations such as health care services, *id.* 12182(a). See *id.* § 12101(a)(3) ("discrimination against individuals with disabilities persists in such critical areas as . . . health services"). In order to achieve this far-reaching goal, Congress patterned the Act's definition of "disability" on the Rehabilitation Act's broad definition of "handicap," expressly invoking Rehabilitation Act statutory and regulatory standards for interpreting the ADA. See 42 U.S.C. § 12201 (requiring adherence to Rehabilitation Act standards). The Rehabilitation Act's definition of "handicap" had itself been expanded in 1974, one year after its original enactment. See *Arline*, 480 U.S. at 278. Congress had concluded that its forerunner, restricted to limitations on employability,

> was too narrow to deal with the range of discriminatory practices in housing, education, and health care programs which stemmed from stereotypical attitudes and ignorance about the handicapped.

Id. at 287 n.3.

This history confirms that the "major life activities" criterion that Congress chose to define "disability," while necessary to provide some limits on the broad scope of an Act that otherwise would cover all "impairments," was never intended to become a linguistic obstacle course that would defeat the Act's fundamental remedial purpose for individuals with serious, irreversible, life-threatening medical conditions. To the contrary, Congress intended to give "disability," like the predecessor term "handicap," a broad definition so that the civil rights protection that it intended to afford all disabled Americans in fact would be available to them. See 42 U.S.C. § 12101(b)(2) (Act's purposes include "provid[ing] clear, strong, consistent, enforceable standards addressing discrimination").

The *Arline* decision, on which the Act is significantly based, further reinforces the appropriateness of construing the statutory term "disability" to encompass a disease with the characteristics of early HIV disease. *Arline* suggests that meritless claims are to be winnowed out less by narrowly construing the definition of who is handicapped than by a careful analysis of whether an individual is otherwise qualified for relief. See 480 U.S. at 285 ("the definition of 'handicapped individual' is broad, but only those individuals who are both handicapped *and* otherwise qualified are eligible for relief") (emphasis in original). Indeed, this Court's holding in *Arline*—that "[a]llowing discrimination based on the contagious effects of a physical impairment would be inconsistent with the basic purpose of" the Rehabilitation Act (*id.* at 284)—is perforce true with respect to the basic purpose of the more far-reaching Americans with Disabilities Act.

For this reason, the Act should be construed to "ensure that [disabled] individuals are not denied jobs or other benefits," such as equal access to basic medical care, "because of the prejudiced attitudes or the ignorance of others" with respect to their disabilities. *Id.* HIV disease is both contagious and generally fatal—a combination of attributes with a unique potency for prompting irrational and discriminatory responses. To construe the Act to deny protection to those with this disease because of a perceived inadequate impact on major life activities would unjustly narrow the scope of this landmark legislation.

B. Persons With Early HIV Disease Are Likely To Be Regarded As Having An Impairment That Substantially Limits Many Major Life Activities

The Act also includes a definition of "disability" that protects persons who are not currently suffering from an impairment that substantially limits a major life activity. In particular, the third subsection of 42 U.S.C. § 12102(2) defines having a "disability" as "being regarded as having such an impairment," whether or not such impairment

presently exists. 42 U.S.C. § 12102(2)(C). In 1994, as the lower courts correctly discerned, respondent Abbott did have an impairment that substantially limited her major life activities. Furthermore, petitioner himself regarded her as having such an impairment, thus bringing her within the scope of the Act's protection by virtue of Section 12102(2)(C).

The basis for petitioner's refusal to provide respondent routine dental care in his office was unquestionably her HIV disease. Petitioner regarded respondent as having an impairment because she was HIV+. The question, therefore, is whether his refusal to provide dental care in his office substantially limited a major life activity.

For two independent reasons, obtaining needed health care is a crucial element of one of the "major life activities" covered by the Act. First, both HHS's Rehabilitation Act regulations and the Justice Department's public accommodations regulations expressly place "caring for one's self" at the top of the list of illustrative "major life activities." See note 10, *supra* (quoting regulations). Obtaining health care services, including routine dental care, is surely a primary component of caring for one's self. Indeed, obtaining such care is especially important for persons suffering from a progressive immunosuppressive disorder such as HIV disease, for whom infection from untreated conditions can pose serious additional risks. See pages 7-8, *supra*.

Second, Congress expressly included the "professional office of a health care provider" among the Act's list of public accommodations that are forbidden to discriminate on the basis of disability. 42 U.S.C. § 12181(7)(F). By treating the provision of health care services as a public accommodation, Congress made plain its view of the critical importance of obtaining access to health care. See also 42 U.S.C. § 12101(a)(3) (finding that "health services" are a "critical" area in which discrimination on the basis of disability persists). For this reason as well, obtaining health care may properly be covered as a major life ac-

tivity. *Cf. Arline*, 480 U.S. at 283 n.10 ("working" is a major life activity because the Act forbids employment discrimination).

Accordingly, petitioner's refusal to treat respondent on the basis of her HIV disease means that respondent has a "disability" under the Act's "regarded as" prong and thus triggers review of the medical reasonableness of that refusal. As this Court observed in *Arline*, by amending the definition of "handicap" to include the "regarded as" component, "Congress acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness." 480 U.S. at 284 (footnote omitted); see *id.* at 284-85 & nn.4-13. These important truths, recognized by this Court more than a decade ago, should guide the Court's interpretation of the ADA, which is designed to remedy discrimination on the basis of disability.

II. ALTHOUGH COURTS ORDINARILY SHOULD DEFER TO THE REASONABLE MEDICAL JUDGMENTS OF PRIVATE HEALTH CARE PROFESSIONALS, PETITIONER'S JUDGMENT WAS NOT MEDICALLY REASONABLE AND THEREFORE IS NOT ENTITLED TO DEFERENCE

Even though respondent was unquestionably disabled within the meaning of the ADA, the question remains whether filling her cavity would have posed "a direct threat" to petitioner's "health or safety." See 42 U.S.C. § 12182(b)(3). The Act defines "direct threat" as "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services." *Id.* The Act thus requires an inquiry not into whether *all* risk may be eliminated, but whether all *significant* risk may be eliminated.

Decisions about the presence of a "direct threat" of infection must be based, not on prejudice or stereotypes, but on reasonable medical judgments.[12] Under the Act, therefore, a health care professional need do no more—and no less—than make a medically reasonable decision about whether and how to treat a contagious patient in light of available epidemiological data and guidelines regarding the significance of and means of reducing the risk of transmission. On this issue, petitioner asserts that the court of appeals erred in not deferring to his assessment of the significance of the risk. See Petitioner's Merits Br. 42-44.

In *Arline*, this Court held that, when assessing the significance of risks related to infectious disease, "courts normally should defer to the reasonable medical judgments of public health officials." 480 U.S. at 288. There is no reason, under the ADA, to deviate from this presumption for cases involving matters—such as infectious disease—that are particularly the province of public health officials. The CDC's guidelines, for example, typically reflect a consensus view of both public and private medical authorities, and therefore should be accorded deference in applying the ADA. This case, however, poses the question left open in *Arline* regarding the extent to which deference also may be due to the judgments of private health care practitioners. See *Arline*, 480 U.S. at 288 n.18.

Ordinarily, substantial deference should be given to employment or accommodation decisions that are genuinely

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[12] *See* 28 C.F.R. § 36.208(c) (1997) ("In determining whether an individual poses a direct threat to the health or safety of others, a public accommodation must make an individualized assessment, based on *reasonable judgment that relies on current medical knowledge or on the best available objective evidence*, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk.") (emphasis added). *Cf. Arline*, 480 U.S. at 288 (listing the same factors for assessing risk).

and rationally founded upon a reasonable, private, medical judgment. See, *e.g.*, AMA *Arline Amicus* Br. at 21-22 n.16; *Kampmeier* v. *Nyquist*, 553 F.2d 296, 299 (2d Cir. 1977) (upholding school board decision to exclude students with vision in only one eye from contact sports because officials "relied on [a reasonable] medical opinion that [the] children . . . [were] not qualified."). Indeed, in disability cases not involving matters of public health, there typically will be no definitive public health guidance available, and so the opinions of private physicians or dentists will inevitably be at issue. These professionals are generally well-qualified to make judgments regarding potential threats to health or safety posed in various scenarios.

More specifically, in cases involving infectious diseases, the parties should not be precluded from relying on private medical opinions when those opinions are medically reasonable and satisfy established standards for expert testimony. This conclusion is fully consistent with the core principle established in *Arline*, that assessments of the significance of risk should be "based on reasonable medical judgments given the state of medical knowledge" concerning the "nature," "duration," "severity," and "probability" of transmission of the disease. *Arline*, 480 U.S. at 288 (quoting AMA *Arline Amicus* Br. at 19). Thus, for example, where a party can show that there is no single consensus but rather a range of reasonable views within the medical profession concerning a disputed issue,[18] then, at the very least, that party should be permitted to present to a factfinder the evidence supporting the party's position. Indeed, where, for example, a physician, alleged to have violated the Act, demonstrates that he or she obtained or made a reasonable medical judg-

[18] This could be the case, for example, when a particular disease is too new for a public health consensus to have formed, when new treatments have been developed but only preliminarily tested, or when substantial research calls materially into question the bases for existing guidelines.

ment, that fact normally should be dispositive that there has been no violation of the Act.

In this case, however, the judgment of petitioner Bragdon was not reasonable and should be given no deference. First, that judgment was inconsistent with the consensus among public and private health authorities in 1994 that providing routine dental care to patients infected with HIV in a dentist's office posed no significant risk of harm to the dentist if universal precautions were followed. The CDC guidelines in place in 1994 on this point were fully consistent with, and explicitly supported and amplified by, the guidance provided and widely disseminated by both the American Dental Association, and more generally, by the AMA. See, *e.g.*, J.A. 225; AMA *Amicus* App. at 1a-2a. Where a consensus exists that there is "little risk" to providing a particular treatment to a patient with a particular type of infection (J.A. 225), private deviations from that view should be deemed presumptively unreasonable.

Second, petitioner did not rely on any substantial scientific evidence in support of his position. As this Court recently reemphasized in the context of admissibility determinations, *all* expert testimony must be scrutinized with an eye toward determining whether the opinions propounded actually draw any support from the underlying scientific proof:

> Trained experts commonly extrapolate from existing data. But nothing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence which is connected to existing data only by the *ipse dixit* of the expert. A court may conclude that there is simply too great an analytical gap between the data and the opinion proffered.

General Elec. Co. v. *Joiner*, 118 S. Ct. 512, 519 (1997). The court of appeals' detailed analysis of the evidence petitioner offered to defend his refusal to treat respondent identified numerous "analytical gap[s]" between underlying data and the view sought to be supported. Only

after the court found all this evidence wanting, considered separately and cumulatively, (Pet. App. 22a-29a), did it finally conclude, consistent with the principles in *Joiner*, that petitioner "failed to present meaningfully probative evidence that treating Ms. Abbott would have posed a medically significant threat to his health or safety." *Id.* at 30a.

Third, deference is less appropriate where, as here, a party seeks to invoke it in defense of his own unilateral action. Notably, petitioner did not attempt, contemporaneously with the event at issue, to seek out an independent private medical opinion concerning the degree of risk posed by treating respondent. This failure is significant, for the question as left open in *Arline* contemplated a scenario in which an employer had sought out an independent private medical opinion. See *Arline*, 480 U.S. at 288 n.18 ("This case does not present, and we do not address, the question whether courts should also defer to the reasonable medical judgments of private physicians *on which an employer has relied.*") (emphasis added). Here, in contrast, petitioner's actions were based on his own judgment in an area—treatment of HIV-infected patients—where he had no special claim to expertise and thus where an unfounded fear might distort his judgment.

Finally, and most fundamentally, petitioner's claim to deference is irreconcilable with his categorical refusal to provide health care to respondent.[14] This is not a case in which a practitioner has sought, consistent with reasonable medical judgment, to modify his practices and procedures in order to minimize personal risk while still reasonably accommodating his patient's needs.[15] Petitioner's attempt

[14] The court of appeals noted that petitioner did not attempt to prove that the hospital treatment he proposed was significantly safer than routine office treatment, but instead claimed "the right to deny entirely routine dental treatment to patients with HIV." Pet. App. 16a n.4.

[15] There certainly will be cases in which a health care worker may seek to take additional precautions when treating a patient with a communicable disease; such precautions would be appropriate if they do not unduly burden the ability of the patient to get needed care and if they reflect a medically reasonable and good faith effort to accommodate the patient's needs as well as the health care worker's reasonable concerns for personal health and safety. In such a situation, there should ordinarily be no basis for a finding of discrimination, but that is not this case.

to defend his absolute position by appealing to the AMA's ethical principle that physicians shall be "free to choose whom to serve" (see Petitioner's Merits Br. 45 n.34, quoting AMA Principle VI) is misguided. The AMA's ethical opinions make clear that this broad principle is bounded by the ethical duty not to refuse treatment to patients on the ground that such treatment would pose some personal risk to the physician. See AMA, *Code of Medical Ethics* §§ 9.12, 9.131 (1996-97 ed.), AMA *Amicus* App. 1a-2a. Indeed, the duty to treat despite some personal risk is inherently a part of what makes medicine a profession rather than a commercial trade—it is "constitutive" of what it means to be a medical professional. See Ezekiel Emanuel, *Do Physicians Have An Obligation To Treat Patients With AIDS?*, 318 N. Eng. J. Med. 1686, 1686-87 (1988). If deference is due to a professional judgment, it can only be because that judgment was made consistent with the critical tenets that separate a profession from a trade. A judgment that conflicts with those tenets is necessarily not a "professional" one, and therefore cannot merit deference.

* * * *

To many in our society, HIV disease raises the specter of an irreversible death sentence, and a protracted and horrible death at that. Fear of contracting this disease can be so great that it provokes decisions based on misinformation and prejudice—and thereby leads to discriminatory conduct without medical justification. It is precisely for this reason that the Americans With Disabilities Act should be construed, in complete harmony with the dictates of medical ethics, to prohibit arbitrary limitations

on the access of an individual to health care because that individual is seropositive for HIV. Based on the overwhelming weight of scientific authority, the long-established standards of the medical and dental professions, and the manifest intent of Congress, respondent should not have been denied dental treatment in the dentist's office.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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APPENDICES

APPENDIX A

CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS AMERICAN MEDICAL ASSOCIATION

Opinion 9.12—Physician-Patient Relationship: Respect for Law and Human Rights. The creation of the physician-patient relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, or any other basis that would constitute invidious discrimination. Furthermore, physicians who are obligated under preexisting contractual arrangements may not decline to accept patients as provided by those arrangements. (I, III, V, VI)

Issued July 1986.

Updated June 1994.

[Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics: Current Opinions With Annotations* 152 (1996-97 ed.).]

Opinion 9.131—HIV-Infected Patients and Physicians. A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive for HIV. Persons who are seropositive should not be subjected to discrimination based on fear or prejudice.

When physicians are unable to provide the services required by an HIV-infected patient, they should make appropriate referrals to those physicians or facilities equipped to provide such services.

A physician who knows that he or she is seropositive should not engage in any activity that creates an identi-

fied risk of transmission of the disease to others. A physician who has HIV disease or who is seropositive should consult colleagues as to which activities the physician can pursue without creating risk to patients. (I, II, IV)

Issued March 1992 based on the report "Ethical Issues in the Growing AIDS Crisis," issued December 1987 (*JAMA*. 1988; **259**: 1360-61).

Updated June 1996.

[Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics: Current Opinions with Annotations* 157 (1996-97 ed.).]

APPENDIX B

PRINCIPLES OF MEDICAL ETHICS I, II, IV & VI AMERICAN MEDICAL ASSOCIATION

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

[Council on Ethical and Judicial Affairs, American Medical Association, *Code of Medical Ethics: Current Opinions With Annotations* xiv (1996-97 ed.).]